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COMMUNITY PARTNERSHIP ORGANIZATIONS:

A Better Way to Gain Participation in Health Programs

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COMMUNITY PARTNERSHIP ORGANIZATIONS:

A Better Way to Gain Participation in Health Programs[1]

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TECHNICAL SERIES

Organization of Community Adults for Participation
in Health Education and Prevention Programs

Robert E. Knittel, "Organization of Community Groups in Support of the Planning Process and Code Enforcement Administration" (PHS No. 1997,1970) 69 pages.

Robert E. Knittel, ed., "Motivation and Attitude Change Components for Trainers of Community Health Aides" (CDC Publication No. 97-524, 1974) 65 pages.

Harold L. Nix, "The Community and Its Involvement in the Study-Planning-Action Process" (HEW Publication No. (CDC) 78-8355, 1977) 205 pages. Available only from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Stock No. 017-023-00120-5.

Ray H. MacNair, "Community Partnership Organizations: A Better Way to Gain Participation in Health Programs" (DHHS Publication No. (CDC) 80-8384, 1980) 33 pages. For administrative copies, write: Centers for Disease Control, Bureau of State Services, Technical Information Services, Atlanta, GA 30333. Larger orders may be purchased from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Community Development and Information Section, "Community Organization for Public Health Measures: A Workshop Manual" (DHHS Publication No. (CDC) 81-8388). Available from Centers for Disease Control, Bureau of State Services, Technical Information Services, Atlanta, GA 30333.

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FOREWORD

This publication, Community Partnership Organizations: A Better Way to Gain Participation in Health Programs, is the fourth in the CDC Technical Series on Organization of Community Adults for Participation in Health Education and Prevention Programs. This is a practical guide to the development and operation of a community organization process that can enable citizen support of and participation in local public health agencies' education and prevention programs. The procedures described by Dr. MacNair have been well attested to by experience with the "locality development" and the "social planning" models of community organization/development work among both rural and urban populations here and abroad.

Although written primarily for use by health educators and public health administrators concerned with the prevention of disease and injury, this publication could be useful to any change agent or planner involved in community development programs and to the community's citizenry as well.

OVERVIEW

This booklet is part of a technical series for health and planning personnel. It describes and discusses a concept which deals with participation and community organization in public health education and prevention programs: the Community Partnership Organization (CPO).

Four basic and practical models for structuring CPOs are described in the section entitled Stage One: Getting Started. In addition, relatively quick ways to (1) maximize the number of channels available for communication about a program and (2) energize the kinds of adult participation needed to achieve specific health objectives are discussed.

The first three models described merit use in health education and prevention programs. The first model uses existing organizations in the community as the initial partners to open the way for participation of their constituents. The unorganized elements of an at-risk population or of the general citizenry of an area are identified and reached by a second model. The third combines aspects of the first two models to bring special programs to recipients scattered over a number of areas. (The fourth model is a quick approach for setting priorities for programs and is used only as a last resort when continuous participation is impossible and decisions and/or reactions need to be obtained quickly.)

An integral part of the CPO is representation from public and private health agencies. A United Way council, or other federation of agencies, and representatives of concerned groups may already exist within a community. The health agency may ask such a council or federation to form an action committee for the program. Frequently, however, such a council or federation does not exist and the organizations essential for promoting participation in reaching a particular health goal need to have their representatives brought into a working alliance for that purpose.

In addition to representation, all public health education and prevention programs need participation to attain their disease or injury reduction goals. The education programs use participation to communicate health facts, confirm new attitudes, and reinforce appropriate habits and lifestyle behaviors; the preventive programs use participation to gain public understanding, public support, and cooperative behavior.

The participation has to be functional to the tasks envisioned by the program planners. The key to cultivating member groups (or partners) for inclusion in a CPO to cooperate with a particular health education and prevention program lies in the answers to the following questions. Whose participation will help communicate the initial and ongoing health education to promote in the community an awareness of the disease or injury problem and an understanding of its prevention? Whose participation will be needed to promote authorization and adoption of the preventive program? Whose participation will be helpful in supporting the financing and

continuance of the prevention? Whose participation can be helpful in the later reinforcement of newly learned behaviors essential to the prevention goals? Sometimes general membership organizations are needed, whereas sometimes more specialized organizations providing particular services are needed.

There is a range of involvement in CPOs that corresponds to the functions expected of participants. Some of these functions are internal; others, external. For example, in some preventive programs, both the health education and the means of prevention may concern the internal physiology of individuals, rather than their external environment. For example, education for both personal hygiene and patient care is oriented towards the consumer's own future behavior and is related to the internal processes of his or her physiologic organism. This type of learning is usually aimed at both children and adults and focuses on personal habits that will lead to a healthful life. Examples are programs that deal with immunization, diet and exercise, lifestyles and life events, or treatments to interrupt the transmission of disease. In these situations, the role of the participating partners in a CPO is to make possible the acceptance and reinforcement of cooperative behavior.

On the other hand, in prevention external to the physiologic organisms of individuals, both health and environmental education are oriented toward present change. That change may occur either (1) in an environmental source of an adverse condition or stimulus or (2) in the actions of the individual and corporate users affected by or affecting that environmental component. From the standpoint of prevention, a change in the hazard at its environmental source is preferable, if not too costly, since it is automatic in its operation. From a cost-effective standpoint, however, it frequently proves necessary to change the users' exposures and/or feedback behaviors. Those individual behaviors, group habits, and corporate activities that are then the keys to correcting environmental influences on health are markedly different in character from the personal hygiene of patient education and the illness behaviors helpful in primary care. Accordingly, the partners for inclusion in a CPO for such programs are a broader representation of all existing community organizations that may help make the particular program operational.

This environmental type of health education is aimed at adults responsible for conditions external to their physiologic organisms. Such education seeks first to change, during the field action of an environmental health program, the adults' immediate responses to or use of some aspect of their environment, such as climatic, inorganic, biologic, nutrient, social/relational, or natural and constructed physical factors. Secondly, to have preventive benefit, such education seeks to stimulate continued adult involvement in self-help and mutual reinforcement of the newly learned behaviors necessary during the "maintenance" and "environmentally improved" phases of the program that follow the environmental correction. The health agency and the CPO for such a program need to plan for such ongoing environmental health education to continue until the new behaviors become part of the local culture and perpetuated as part of the mores.

Readers of this book who are public health professionals may wish to think of the partner-choosing function in terms of tasks the health agency, the CPO, and the community or population at-risk may have to perform to accomplish an epidemiologically significant intervention capable of reducing the incidence of a specific disease or injury among the population of their community. Other readers may wish to skip the following three paragraphs and go directly to the section on Choosing Partners for examples of varied CPO partner choices for different health programs.

For the public health professional (the public health officer, the planner, and the educator and their community organization facilitator) a helpful starting point is the epidemiologists' concept of a system of external stimuli and internal responses affecting a person's health. Brian MacMahon et al., in "Epidemiologic Methods," writes, "Prevention and epidemiology are concerned predominately with those successions of events which result in the exposure of specific types of individuals to specific types of environments leading to or aggravating bodily changes in those individuals. . . . Fortunately, to effect preventive measures, it is not necessary to understand causal mechanisms in their entirety. Even knowledge of one small component may allow some degree of prevention" (Boston: Little, Brown and Company, 1960, pp. 22 and 18). Since then, epidemiologists conceive those factors as a "web of causation." Concomitant in a web of causation are not only a factor or chain of factors "necessary" to the occurrence of a specific disease or injury, but also those contributing factors "sufficient" for a disability to become "manifest" rather than held "latent" in a "susceptible" individual.

In the context of a community and its population, this concept of the webs of causation is called among planners and other scientists, such as biologists and environmentalists, a "human ecosystem." Public health education and preventive programs are designed to intervene in the human ecosystem of a community and its population to change components in those webs of causation. Reduction of a certain amount of disease or injury may be effected by change in any relevant component in the system. Those changes may be (1) in the environmental stressers that stimulate physiologic responses, (2) in the internal processes of the individual organism that responds to those stimuli, or (3) in exposure and feedback behaviors of individuals and corporate actors in the population. Each alternative intervention entails distinctive educational and preventive operations. The performance and performers of those operations are the keys to choosing CPO partners.

CHOOSING PARTNERS

This booklet does not detail the varieties of existing organizations to approach to form partnerships specifically relevant to each of the various types of health education and preventive programs. However, experience has shown that partners for a CPO must be both pertinent to the work and able to participate positively in order to avoid spotty performance, short-lived

results, or lack of partner initiative. The booklet author and the series editor agree that organizational and citizen-consumer representation can be planned ahead for different health education and preventive programs.

The following examples of CPO partners useful for several types of health education and preventive programs will help the reader envision the applicability of this community organization technique to programs to be undertaken by a local private or public health agency.

Partners for External Prevention

The CPOs of largest scope and size are those that require awareness, understanding, and the support of the whole population of the community to obtain a public decision authorizing the start and/or continuance of an environmental program that either is misunderstood (and thus controversial) or involves a major public investment. The intervention involved usually is a change in some environmental component at its source. Examples are(1) the adoption of a public water system and the requirement for its use to eliminate water-borne disease agents in drinking water and subsequent voting of bonds to finance it and (2) the adoption of fluoridation of that water system to reduce the chronic dental disease of caries and subsequent voting its continuance as a preventive program.

In a program to correct the environmental source of a disease or injury hazard, the participation of CPO partners may entail obtaining popular support of an impersonal service that can influence prevention programs. Examples of such programs are public water systems, sewer systems, fluoridation, and solid wastes collection and disposal. Authorization, financing (including issuance of bonds), and/or continuance of those services are dependent on public decisions by city and county councils or by referendum ballot by the municipal electorate. In such programs, the role of the participating CPO partners is to promote community awareness and understanding to support the public decision. Once such a program becomes an accepted routine, another public department of the local government usually operates the service. But it remains a health agency responsibility to get policy approved and to set and monitor the pertinent prevention standards.

The partners in a CPO for external prevention are those that can help communicate the awareness and understanding of those health objectives to any specific segment of the population whose support may be essential for such adoptions and votes. But, in addition, the CPO must have partners whose expertise will help the public or the elected and administrative officials grasp the health facts in spite of misrepresentations that may be spread by misinformed and/or biased opponents. The potential partners for CPOs with those missions could include representation from the following:

1. To help communicate to all or parts of the population, include leaders from existing organizations in the community that represent:
   AFL-CIO locals and other labor unions; Chambers of Commerce and boards

of trade; citizen groups; civic organizations; consumer groups; each minority or ethnic part of the community population; farmers' organizations; fraternal and service clubs; language groups other than English; local associations of religious institutions or their charitable/service affiliates; manufacturers' associations and large employers; organizations of the aged; parental and homemaker associations; patriotic and veteran societies; real estate and builders' associations; social, sports, and other recreational clubs; youth organizations.

2. To help prepare materials and give expert discussions or talks at public and private meetings, public hearings, or in court cases, include: Educators; health professionals and paraprofessionals, such as physicians (including pediatricians, internists, geriatricians, other pertinent specialists), dentists, psychologists, osteopaths, nurses, hygienists, chiropractors, healers; professional engineers and related specialists, such as civil, sanitary, water, pollution specialists, sanitarians, environmentalists; representatives of pertinent organizations such as financial institutions, the media and communicating arts, and the design and planning professions; social work professionals.

In other words, any existing organizations whose membership will be specifically concerned with bringing about a particular environmental change or who will be influential in the adoption of the particular preventive program and the authorization of standards or public investment must be included in the CPO.

There are a considerable number of environmental health programs that require business corporations and residential property owners and tenants to attain and maintain certain standards of sanitation, nonpollution, and safety. In these instances, CPO participation is focused on communicating continuously to the at-risk population and the private parties responsible for observing the standards rather than on reaching for a few months the broad population for their support on a public decision. At the start of such programs there may be some public actions to cooperate with the private parties in clean-up, rat and vector control, or other actions to achieve the proper standards. But the success of such programs invariably requires that some people or corporations change some behavior in order to gain and maintain improved residential, occupational, recreational, or food-handling conditions. This changed behavior must then become habitual with the private parties and part of the community culture if program benefits are to be self-maintaining without further public health intervention.

Changes in environmental conditions and maintenance of standards for health and safety are usually private responsibilities. The public health agency (or one of its sister departments in the local government) then monitors, inspects, or advises the private parties to be sure they all individually and mutually observe hygienic standards and create no nuisance. Where

private investments or private corporate and personal activities are crucial for correcting and preventing health or safety hazards, an environmental prevention program requires a shorter list of partners. In such cases, the preventive intervention may be undertaken by the private parties or perhaps required of them by a municipal or State government. The intervention may be at the source of an environmental hazard. It may alternatively be in the corporate activities, cultural habits, or personal behaviors that (a) expose a person to a hazard or stresser or (b) create a hazard or stresser for others by feedback to their environment such as improper disposal of wastes which contaminate the environment, unhygienic food handling in restaurants, or littering and other abuses of the residential environment. The more pertinent the CPO partners are to some function in the accomplishment of the intervention alternative chosen--source correction versus behavior/activity correction--the more effective the partnership between the health agency and its client groups will be.

There are two kinds of exposure behavior. First, the performance of routines during occupational, residential, or recreational activities can bring one into contact with hazardous materials or conditions. Secondly,a more self-imposed risk of contact with an environmental hazard occurs when one chooses to engage in certain lifestyle habits in which one runs the risk of disease or injury. But, as previously stated, whenever exposure behavior can be effectively changed by health education or preventive measures, it can be a more cost-saving alternative means of prevention than changes at an environmental source requiring large investments to gain the same benefits.

There are three major divisions of feedback behavior to different components of a human's environment that have implications for health. First, there is the sometimes supportive, sometimes stressful personal emotional and behavioral feedback involved in face-to-face primary groups in the home, on the job, or in the neighborhood. The "life events" that break off or add on such relations in too rapid succession are also highly suspect as stressers to health. Secondly, there are cultural usages--the personal habits that are customary in an area that litter or impair the physical environment of human settlements. Also there are the customary tastes and habits that so often impair the healthful use of the nutrient component of a group's environment. The third division of feedback represents the contaminative behaviors of persons or corporations that pollute the biologic, inorganic, or climatic components of environment. The changing of one or another of these feedback behaviors is an important alternative for gaining some reduction of incidence of disease or injury in many preventive programs.

Examples of lists of partners for these varied environmental prevention programs are:

1. The CPOs for food handling problems should be representative of: Consumers, homemakers' associations, etc.; owner-operators of stores and restaurants; the media, communicating arts, and educators

(schools); the private and public health agencies, including their medical, engineering, nutritional, and educational expertise; workers in such establishments.

2. In contrast, a community-wide CPO for a program dealing with the residential environment needs to have partners who represent:
Other organizations, such as religious, civic, fraternal, and recreational or educational groups that typically serve the project areas where the preventive program will be active; programs relating to basic sanitation, rat and other vector control, lead paint or monoxide poisoning, fire hazards, housing and neighborhood standards for safety, overcrowding, weather tightness and heating and cooling control, etc., both in the dwelling and on the nearby streets and recreation areas; the lending institutions; the local council of neighborhood associations; the neighborhood boards of trade; and the property owners' and the tenants' associations.

3. There should be independent CPOs for each neighborhood or village to permit the residents of each project area to feel the project is theirs. These CPOs should begin in time to participate in the health education preceding the planning of environmental improvements. The same CPOs would serve during the planning process and throughout the activities leading to change of environmental conditions and/or behavior. At this local level the residents may need to engage in self-help work so that they will later understand and be motivated to reinforce each other to help maintain the environmental improvements and the private and public investment therein.

At both the community-wide and the project-area levels, CPOs also need to include among the partners the following:

Representatives of pertinent professions, such as designers, planners, social workers, and sanitarians; representatives of the several trades that may be employed in doing the environmental corrections and who can advise on quality workmanship and on precautions against cost gouging; and representatives of the management, editorial staff, and reporters of the local media, such as the daily and weekly press, radio, and TV.

Lifestyles that involve some hazard to health frequently create a self-imposed environmental risk. By smoking, one breathes heavily polluted air. By overeating, overdrinking, or eating unbalanced meals or engaging in fad diets, one ignores the nutrient potential of one's environment and runs the risk of nutritional deficiency. Correction of such personal habits requires a health information public awareness program concerning these possibilities for future health risks. But awareness is not enough. The prevention or the change of lifestyle habit takes not only self-will but also encouragement by the significant others in the life of the person at risk.

Health education and prevention programs dealing with lifestyle depend wholly on changing personal habits for success, not on changes in community

environment. The local CPO partners for such programs must be made up of persons to whom local folk turn for their health advice and personal counseling. In other words, the CPO must include those who are influential with the target population and who can reach them with information that is discussed and mulled over in the folk gossip that (1) forms and reforms attitudes and (2) reinforces and confirms changed behaviors as acceptable, sensible, and appropriate to one's way of life. Moreover, the basis for most excessive "gratification" behaviors--overeating, chainsmoking, alcohol abuse, drug abuse--is often closely linked with stress factors. Thus, there is a need for involvement of mental health organizations, particularly those interested in prevention.

Any of the environmental preventive programs that require behavior changes to reach their goals can use the photogenic aspects of the behaviors and environmental conditions to increase the efficacy of the communication to specific parts of the community. The rat control and lead-paint poisoning programs in Troy, New York, for example, made effective use of two photonovels--booklets written, acted, and photographed by residents of each client neighborhood. The photonovel uses photographs instead of cartoons and tells a dramatic story by presenting the participants' talk in balloons as in comic books. To produce an effective photonovel, the health agency and CPO need to have a committee of neighborhood participants to do the book. The printed result stimulates the target area gossip, since thecharacters and conditions photographed are recognizable to the readers. In contrast, professionally authored and acted photonovels, such as one done for venereal disease control in the same State, do not seem as effective, probably because known environmental conditions and recognized persons do not appear.

Partners for Internal Prevention

When the focus of cost-effective intervention in a community's human ecosystem shifts from environmental conditions and their related behaviors to processes internal to the individual physiologic organism, the cast of partners for a CPO changes. Usually, fewer partners are needed, and the emphasis may be more on coordination of the professions in programs that aim at prevention of disability from a manifest disease. Yet, wherever the learning and reinforcement of new behaviors are important, many of the same existing community resources instrumental in outreach communication to populations at-risk are the same needed to gain like behavioral changes in environmental prevention.

Health education programs eliciting informed self-help, cooperatively reinforced by others, can strengthen the adaptive capacity of the body to cope with or hold latent diseases for which it may have a generalized susceptibility. Patient education, school hygiene training, media releases, and reminders from family and friends all induce a person to remember to be regular about such matters as medicine-taking, insulin administration, bathing, toothbrushing and flossing, diet, and exercise.

The following paragraphs provide examples of partners typically found useful to involve in the CPOs for health education and preventive programs

that focus on an individual's internal processes, from immunization at the physiologic level to relearning personal behavior responses to cultural stressers at the psychiatric level.

Immunization: The lists of CPO partners for immunization programs include, according to the "Guidelines for Volunteer Participation in Childhood Immunization Programs" (New York: National League for Nursing, 1980), the following community organizations whose representatives serve on four subcommittees: (1) Public Awareness Committee; (2) Professional Education Committee; (3) Utilization of Community and Volunteer Resources Committee; and (4) Standardized "Parent-Maintained" Immunization Record Committee (all coordinated by an Immunization Action Steering Committee for the county-wide immunization campaign):

Ad Club; AFL-CIO council; American Legion and Auxiliary; American Red Cross; Association of Broadcasters; auxiliaries to medical societies; Boys' Clubs; Boy Scouts; Camp Fire Girls; Cerebral Palsy Association; city-county health departments; Community Chest/United Way; Community Services Council; Coordinating Council of Parent-Teacher Associations; Council of Kiwanis Clubs; Council of Negro Women; County Extension Service; day care centers; District Nurses Association; Federation of Teachers; Federation of Women's Clubs; foundations; Girls' Clubs; Girl Scouts; Head Start; Health Systems Agencies; home health agencies; hospital auxiliaries; Junior Association of Commerce; Junior League; Lions Clubs; little leagues; local League of Nursing unit; mayor's wife or county executive's wife; Medical Society; National Foundation (March of Dimes); neighborhood health centers; Press Association; Retired Senior Volunteer Program (RSVP); Rotary; Toastmistress Clubs; Urban League; Veterans Hospitals; Voluntary Action Center; Volunteers in Service to America (VISTA); Women's Clubs; Women's Ad Club.

Diabetes Health Education: The local CPO partners for diabetes health education include:

Industry and commercial organizations that are helpful, such as pharmacists, insurance companies (such as Blue Cross/Blue Shield), Health Maintenance Organizations, and multiphasic screening programs; local American Nurses Association and/or National League for Nursing and/or NLN chapters, public health nurses, nurse practitioners, and home health agencies; local medical society and family practice groups; representatives influential in local professional societies; representatives of certain voluntary and community organizations, such as regional clubs (Jaycees, Lions, Elks, Chambers of Commerce, Golden Agers, and women's organizations); representatives of the media and the local libraries; specialists in the local chapter of the American Association of Diabetes Educators and nurse members of the American Diabetes Association; specialists, including representatives from the local or State endocrine society, cardiologists, dentists, dermatologists, nephrologists, neurologists, ophthamologists/optometrists, psychologists, psychiatrists, and podiatrists.

Venereal Disease: The voluntary sector organizations who have participated in venereal disease control efforts include:
AFL/CIO locals' community service representatives; American Social Health Association; B'nai B'rith; Boys' Clubs, Boy Scouts, Girl Scouts; community organizations such as representatives from the retail druggists, Planned Parenthood, Urban League, PTA, Optimists, Jaycees, Kiwanis, and Lions; coordinating element of professional talent representing family physicians, physical educators, obstetricians and gynecologists, Red Cross, nurses, and school health personnel; Junior League and women's clubs; local citizen's councils or hot-lines for VD information and control; local members of the American Venereal Disease Association; and related United Way agencies.

High Blood Pressure: According to a 1974 publication of the Health Education Branch of the National Heart, Lung, and Blood Institute, in developing a community high blood pressure program, the CPO partners to be invited include:
Bankers, educators, and consumer groups; citizens for the treatment of high blood pressure; County Cooperative Extension Service; health agency personnel; health care professionals; health insurance companies; health planning experts; Health Systems Agency; Heart Association; hospitals; kidney foundation; leaders of religious institutions; local government leaders; local high blood pressure information center; local industrial and commercial leaders; local labor union leaders; Medical Society; news media and Ad Club; organizations serving ethnic, racial, or age groups in the population that have more than normal risk of hypertension; pharmacies; Red Cross; Regional Medical Program; and service and fraternal clubs.

Cancer Control and Rehabilitation: In community clinical oncology programs for cancer control and rehabilitation, National Cancer Institute demonstrations in Grand Rapids and Allentown have found the following partners essential for promoting better coordinated service to cancer patients in the community:
A homemaker; a leading lawyer; a principal manufacturer; an educator or school counselor; an employment agency executive; area hospitals; Blue Cross; Children's Leukemia Foundation; county association of osteopathic physicians and surgeons; county health department; county medical society; county unit of the American Cancer Society; Director of Medical Clinical Toxicology programs; electric utility company; hospital council; local Health Systems Agency; nurses association; practitioners of pastoral counseling; public health nursing service; several cancer patients; and the local medical oncology program.

The partners are selected, not for their help in communicating to the general public, but for their ability to improve the coordinated service to cancer patients, to prevent patients' further disability and help to their rehabilitation, or to counsel with them and their families in terminal cases. Therefore, this list of CPO partners is

made up predominantly of health professionals, rather than lay and media organizations.

Mental Health: In a survey preceding its 1976 Pilot Conference on Primary Prevention, the National Institute of Mental Health asked 34 community mental health programs in 3 mid-Atlantic States to identify which of 15 institutions and community groups they collaborated with regularly for primary prevention. In rank order, the list includes: public schools; social service agencies; nursery or day care programs; clergy; law enforcement agencies; other mental health facilities; public health department or other health agencies; youth-serving organizations; mental heath associations; Alcoholics Anonymous or other self-help groups; physicians; family planning services; community health agencies; employment services; service clubs; the local agency on aging; hot-line volunteers; public housing management; agencies for the blind; local colleges; veterans organizations; pediatric service; maternity service; obstetrics clinic; burn unit; and Parents Anonymous.

Another list includes the following types of community organizations who are kept informed and ready to be involved in specific mental health education and prevention activities:

Professional resources: General hospitals, crisis/emergency services, nursing homes, child guidance centers, private social service agencies, child care agencies, public health departments, physicians, pharmacists.

Lay resources: Public welfare agencies, poverty agencies, religious institutions, housing agencies, courts, neighborhood organizations, self-help groups, teachers, police, union locals, ethnic organizations, and social clubs. From among them some are drawn into active participation according to the needs of a specific program, e.g., marital disruption, bereavement, other emotional distress, maladaptation, maladjustment, needless psychopathology and human misery, on the one hand, and promotion of social and functional competence, coping capacities, and ego strengths, on the other hand.

The types of CPO partners in mental health prevention programs vary according to the area of concern and the means of resolution. Some mental disorders of known etiology are preventable by either external or internal measures. External measures include environmental programs to reduce the incidence of some acute and chronic nerve and brain syndromes resulting from (a) poisoning by certain toxic or chemical substances, e.g., lead-based paints; (b) nutritional deficiencies, e.g., pellagra, beriberi; and (c) injuries and other physical traumas. Some internal prevention programs can reduce mental disorders relating to (d) infections, e.g., encephalitis, rubella, syphilis; (e) general systemic diseases, e.g., erythroblastosis fetalis, cretinism; and (f) genetic diseases, e.g., PKU,

galactosemia. Other preventive measures, some external, some internal, are reported as in prospect, thanks to advances in understanding the biochemistry and electrochemistry of communications in the nervous system. The state of the art for reduction of emotional disorders and promotion of mental health, however, has a large behavioral or relational aspect. Mental health education, individual and group counseling, and community organization to change behaviors and to develop, correct, or replace supportive relationships, are important in the psycho-socio-cultural-educational approach characteristic of much professional mental activity. The lists of partners in the two preceding paragraphs are based on experience in organizing CPOs for the last of these four preventive strategies to prevent mental disabilities.

In any preventive program that elicits changes of attitudes and behaviors, the mix of existing organizations in the community to consider for partnership in a CPO will be decided on the basis of both their concerns with the problem and their contributions to making the selected program operational. The mix may have to include representation of those persons in the community who can be influential in the informal face-to-face statements necessary to start a flow of conversations in the gossip-chains of the population whose attitudes and behaviors need some change. Such conversations among peers, friends, or neighbors are where one tests out the sense and acceptability of attitudinal and behavioral changes. The addition to a CPO of such communications resources requires identification of those who are respected as "leaders of opinion," i.e., persons reputed to be influential in health matters among each population group that has a distinctive subculture.

INTERVENTION FOCUS SETS CPO FORM AND DEFINES COMMUNITY SIZE

Whoever decides that a particular health program merits priority attention has to answer three questions before existing organizations can be selected for participation. First, what is the etiology of the disease or injury that is the focus of the health problem? Secondly, at what points in the human ecosystem of the community would intervention make a correction or change important enough in the etiology to prevent or reduce occurrence of the problem in the population? And, thirdly, which of the alternative interventions available would be most cost-effective in improving the health status of the community? After answering these questions, it then becomes possible to analyze which organizations and population groups have members that either would be affected by the health objective or would be involved in effecting some role in the chosen intervention. Those that meet either or both criteria can then be listed in a directory and approached for participation in a CPO.

In this booklet and in the others of this Technical Series on Organization of Community Adults for Participation in Health Education and Prevention Programs, the word "community" embraces several types and sizes of human

settlements. Health professionals and planners think of a community as varying according to program objectives. Sometimes it is an area and population that is coterminous with the legal jurisdiction, i.e., city, town, county, or special district. Sometimes it is a village, neighborhood, or group of neighborhoods, much smaller in size than the legal jurisdiction. Sometimes, at the other extreme, it may even be a metropolitan region or a catchment area.

The participation and community organization methods discussed in this booklet are pertinent to forming community partnership structures to heighten health education and prevention participation within each of those sizes and types of communities. It is simply a matter of knowing the prevention alternatives to be undertaken in a given area and bringing representatives of all appropriate organizations and population groups in that area into partnership.

A suggested reading list pertaining to several aspects of Community Partnership Organizations may be obtained from the Center for Disease Control, Attention: Technical Information Services, Bureau of State Services, Atlanta, Georgia 30333.

DEFINITION AND PURPOSE OF COMMUNITY PARTNERSHIP ORGANIZATIONS

This booklet is about a new and more effective method of improving health education and programs that prevent diseases and injuries within a community. The method is called a community partnership organization (CPO) because those three words best describe the concept. The CPO is a community concept in that optimally it involves all segments of a community. The word partnership indicates that this type of community organization is like a business partnership where power and influence is shared along with the benefits. Finally, the word organization is used to complete the phrase, because a CPO does require organization as wide as the area that is the focus of the concern that brings it into being. It also requires the time, thought, and effort it takes to achieve an operating organization.

Because of past experience, some public administrators may not want to get into activities which would involve citizen participation. In such cases, they or their colleagues have been disappointed and frustrated (1) by the tokenism for citizen input legally required in certain programs (2) by the amorphous, indeterminate, and permissive characteristics of some early phases of community development procedures or (3) by the confrontation methods of some advocacy tactics.

The CPO method is different. First, the CPO is a voluntary partnership of citizens and professionals, consumers and producers, and residential and occupational associations. Secondly, the CPO is useful in the second or program-oriented stage of community development practice. It is more directive it focuses on achieving goals in a specific problem area. In that respect its procedures differ from the traditional start of community development among an unorganized and goalless population. Furthermore, it does not use the controversy provoking techniques of some advocacy tactics. Yet it is not unlike a stage that follows the starting phase of either traditional or advocacy procedures. That is the stage when near readiness for consensus and active cooperation in a program requires change of early structure and leadership to those suited to engaging in the activities of an ongoing program.

But what of the time involved? Can health planners and administrators afford to take time away from other important work to facilitate and consult with a community partnership organization? The question may be, can they afford not to invest time in finding out (a) what consumers really need, (b) how citizens respond to what is now provided, and (c) how effective present communication is in involving specific parts of a community's population? Can one afford to assume any longer that health experts behind office desks know all the problems or all the solutions? The only way to influence or educate people about health and the prevention of illness is by talking their language and meeting their needs. This is practical common sense, but it is also our responsibility as employees of public agencies.

Indeed there are many risks, pitfalls, and complications in organizing and maintaining Community Partnership Organizations. But the potential for success is great. CPOs have proven themselves successful in several communities and can work in others if administrators and citizens will commit themselves to take the time and effort.

This booklet is designed to give one the inspiration and guidance to get started and to make the CPO method work for the types of programs cited in the Introduction. One can start off gradually until the staff and participant partners have confidence and success to go on.

STAGE ONE: GETTING STARTED

Community Partnership Organizations (CPOs) are often the answer to community problems which are not being solved because not enough people, or not enough of the appropriate people, are responding to them. For example, when an industry in a community pollutes the surrounding air, the problem can be remedied by simply enforcing an antipollution law on the books. But if legal enforcement requires public pressure, that problem is one that would yield to a CPO.

CPOs are also useful when the problem is one that affects people in a personal, emotional way. Teenage pregnancy and alcoholism are examples of difficulties which many people would not bring to the attention of a public health agency. However, through the mechanism of a CPO, these same people might hear their neighbors discussing health services and might more readily seek help and information.

Another type of problem which often yields to the efforts of a CPO is one that is so large or so widespread in a community that it cannot be tackled by any one agency or group. Typical of such problems would be the ones experienced by people in a community which had a shortage of physicians or found that low-income families had an especially difficult time obtaining a regular doctor.

You should also decide whether or not your community is one in which a CPO could flourish. Ideally, this means that there is not a large transient population; that community leaders are interested supporters of public health planning; that the power structure represents all the diverse parts and levels of the community; that local government has a supportive, democratic style; that health agencies are made up of cooperative people; and that citizens in all parts of the community have had success working together on mutual problems.

Naturally this community and these conditions do not exist anywhere this side of utopia. This ideal is used merely as a yardstick for measuring or predicting possible success. Obviously, the more favorable conditions you have, the easier the CPO will be to organize and the more productive it will be. However, the more favorable conditions you have, the less you may need the CPO to improve the health status of the community.

In any case, assuming that a problem exists and a community partnership could provide solutions, it is time to organize one. It is usually the administrator of a public health agency who makes this decision and who consequently begins to look for a person who can facilitate the organization and continued operation of the CPO.

Choosing a Facilitator

Chances are the administrator will find such a facilitator within the agency itself. A public health educator or other staff member might be chosen to

function in this capacity if he or she is given time off from regularly assigned duties. If no one on the health agency's staff is available, the administrator might look to other community agencies and organizations, such as United Way, the city department of human resources, or a community action agency.

What kinds of people are facilitators? What will their functions be? In choosing a facilitator, the administrator will want to keep in mind what is expected of this person. In general, facilitators should be able to listen, collaborate, and consult. Actually, facilitators are similar to what used to be called community organization workers, except that they are usually staff members of city or county health agencies with little or no professional training in community organization.

Facilitators must be able to win the trust and confidence of others they work with, including people who are very unlike them--people of a different color, national origin, or social and cultural group. They should have a talent for feeling at home with a wide variety of people in a wide variety of places.

To do this, facilitators need to have many of the personal characteristics of a saint, some very worldly talents for attracting money and attention to the work of the CPO, and the toughness of a union organizer (in addition to the help of a consultant).

Facilitators also should have a good sense of timing--knowing what to do and when. They should be a combination of an enabler, a role model, a stimulator, a guide, a promoter, a coach, a staff assistant, an idea person, and a research assistant.

Assuming such a person can be found or some reasonable facsimile of such a person, he or she should understand thoroughly what facilitators are and are not expected to do. It should be clear at the start, for example, that facilitators do not have an advocacy role. The only thing facilitators advocate is participation. Their job is to help people become their own advocates but not to speak or fight for them.

Facilitators should not be brokers or go-betweens for groups and individuals either. Again, the facilitator's goal should be to bring people face to face so they can negotiate with each other directly rather than through a third party. On the other hand, the facilitator does and should make these negotiations easier by introducing people to each other and seeing to it that the rules for discussing and negotiating are enforced.

Refereeing the rules of order is especially important when dealing with groups who distrust the democratic process because they have had no successful experience with it. They will be much more amenable to group discussion and negotiation when they find out that everyone can be heard and that everyone does indeed have a voice in the proceedings. Facilitators should get the group to agree that: (1) everyone has a chance to participate, and (2) no one

shall participate excessively. A key job of facilitators is finding hitherto undiscovered leaders in the community and putting them in touch with each other. Again, it is not a matter of choosing leaders but of encouraging natural leaders to come forth and getting them to work together.

Finally, facilitators are needed to encourage people to participate in CPOs, to keep their interest alive, and to prevent destructive conflicts in and among groups. We will discuss these responsibilities in the next chapter when we deal with later stages in the CPO development.

To accomplish all of this, facilitators use the technique of supportive neutrality. They get to know as many participants as possible by taking an informal part in their meetings. They keep their relationship to the group clear by pointing out what they can and cannot do, will and will not do. They encourage groups to make their own rules for decisionmaking and train people, if necessary, for participation very early in the CPO process.

Facilitators help groups attain goals by offering alternative ways of reaching them. They use demonstrations to get people over the fear of innovations. Most importantly, they get people to trust each other by encouraging them to be sensitive to each other's words and feelings, to be open, and to respect each other. A partnership in the true sense of the word depends on their skills in achieving mutual trust among all participants.

Facilitators also see to it that people get emotional rewards and satisfaction from their efforts by showing a rewarding, positive attitude, and by giving credit whenever it is due.

Choosing and Training Personnel

As soon as a facilitator has been chosen, the next job is to assign a staff to work with the facilitator to expand the undertaking. (Obviously, the size of the staff and the amount of time they spend depend upon the size of the work load.)

Staff people arrange meetings, attend meetings to explain what the meeting was intended to accomplish, and make contacts with and between people to get activities rolling. Like facilitators, they take a back seat as much as possible, preferring to pave the way for participation instead of taking the role of activist or advocate.

Like facilitators, staff people need some knowledge of public health, some knowledge of the community, and of organizational ability. For this reason, many facilitators look to persons on their own staffs who are in touch with people in the community on a regular basis, i.e., public health nurses, home health aides, homemaker aides, or health educators. Volunteers who work with public health agencies regularly are another source of staff help.

Another option is to ask another agency in the community to provide personnel to staff the CPO. The right people can probably be found in United Way, community action programs, Cooperative Extension Services, community education

programs, citizen councils, community development programs, the city department of human resources, or the division of social services. If none of these agencies can provide enough human resources, a number of agencies could deploy some of their staff members to the CPO for a joint effort.

Once the personnel have been selected, there should be an opportunity for them to learn more about what they need to do and especially how they need to do it. In fact, facilitators often need additional training to carry out their functions effectively.

Both content and teaching techniques must be tailormade for the group. Perhaps that is the main characteristic of training for work with CPOs. Individuals may want to learn more about communication, procedures for organizing, agency practices, or health problems. Whatever the specific needs are, health educators and training specialists in adult education can help design the curriculum and suggest the appropriate methods of teaching. These might include workshops, lecture/discussion format, role playing, film/discussion format, question-and-answer techniques, programmed instruction, experiential counseling, role modeling/role play/games, structured or unstructured group discussion, or video tapes. Copies of this manual could be used as a text.

Once content and teaching technique have been chosen to fit the requirements of the participants, an instructor should be found who is comfortable with the teaching method and the students. It is a good idea to choose someone other than the facilitator to lead the training sessions in order to avoid putting the instructor in an administrative position. The local county or area Community Development Specialist of the State University's Cooperative Extension Service could be a good choice.

Convening a Steering Committee

At this uncertain stage of the organization process, people usually look to one assertive person, perhaps a leading decisionmaker in the community, to lend credibility to the undertaking. To begin with, this person might convene a core group of interested, knowledgeable people to act as an ad hoc steering committee.

The members of this group should be experienced at getting organizations started and should represent the various parts and interests of the community which will be affected by the CPO. For example, one type of steering committee might consist of two public health officials, a social worker skilled in community organization techniques, a city or county official, three neighborhood representatives including at least one from a low-income neighborhood, a health worker in a poverty agency, two other representatives of health agencies, and a leader from the business community.

The job of the steering committee is to make decisions about procedure in order to set the tone and style for the organization which is being planned. Members of the committee must tread a delicate line between frustrating

vagueness and crippling rigidity. Their job is to clearly indicate a direction, while not making the kinds of decisions which will irrevocably commit the group to one specific road or another.

The group might begin by discussing the needs or problems which brought it together and deciding whether or not a Community Partnership Organization could be helpful. What was the result of previous efforts to solve this problem? Which community groups are affected by it or interested in it? How do they feel about it?

If the steering committee decides the situation and the time are right to move ahead with a CPO, and if the support of key segments of the community seems to be behind the effort, work can begin on outlining the structure and function of the organization. Of course, the purpose of the organization and its broad goals should be the underlying foundation for these decisions.

Again, the steering committee should assume that the organization being planned will change and grow as it moves ahead. Nothing should be nailed down so tightly that change and growth are choked off.

On the other hand, it is a good idea to move the organization in the direction of a level or style. The method by which representatives are selected and the structure of the CPO will determine this to some extent.

Selecting Representatives

One of the most successful ways of getting good representation from organized community groups is to let them choose their own representatives. It is important, however, that this be done by the whole group, not just by an officer. Facilitators should therefore make sure that the representative is selected at a group meeting so that the person chosen will represent the group.

When this is done, the person chosen will probably be motivated because he or she is responsible to an organization. In addition, delegated representatives are usually more active participants because they are expected to advocate their groups' points of view during discussions and planning sessions. Chances are this type of representative is also better informed or can get information more readily whenever facts are needed.

The best way to secure representation from neighborhoods or citizens groups which are not organized well enough to elect their own representatives is to ask an agency which is close to the people involved--Community Action, for example--to make the selection. Churches are also often in a position to choose a spokesperson for groups of people in a community.

Planning the Structure

As a general rule, the structure of a CPO should be flexible enough to allow maximum participation and action with minimum delays or frustrations. At the

same time, the organization must be structured enough so that it does not lose its continuity or become confusing and grossly inefficient.

Above all, the structure should be tailormade to the place, people, and problems involved. This being the case, no two CPOs will ever be exactly alike, but the following four CPO structures can serve as basic models which can be modified to suit the circumstances in each individual situation: alliances, area structures, special interest structures, and temporary planning structures.

(1) Alliances:

In cases where a CPO will consist of community groups which are already organized, an alliance can be formed with very little effort. The organizations and their citizen participants simply become members of the CPO.

Flexibility is an advantage of this system. Only those organizations which have an interest in a particular project are involved at any one time. When the objectives change, some can drop out while others may want to join. The work of the alliance can be coordinated by the steering committee until a more permanent council is formed.

The kinds of organizations which can be included in an alliance include the following: local chapters of the American Cancer Society or Red Cross; hospital boards; civic and fraternal organizations; tenant and homeowner associations; neighborhood clubs; advisory committees to public agencies; professional associations, especially of health professionals; groups of consumers and conservationists; PTAs; labor unions, chambers of commerce and boards of trade; and farm cooperatives.

When there are too many consumer groups or neighborhood associations, it may be necessary to select participants at random and rotate membership in the central CPO council to keep it small enough to be manageable.

(2) Area Structures:

Members of this type of CPO are neighborhood clubs or associations which are then combined into area councils. The neighborhood associations can, if necessary, be subdivided into clusters of blocks or even households. These will participate when it is appropriate or necessary to do so. This structure involves portions of the community and is especially useful for education or prevention programs aimed at parts of neighborhoods or individual households.

The boundaries of the neighborhood clusters can be drawn so they coincide with those used in epidemiological or planning studies. If this is done, it will be easier to evaluate the impact of the CPO based on before-and-after statistics from the same groups of households or blocks. The boundaries of the areas should be drawn so that they make sense to the residents of the area and are easy to identify and remember. Finally, a central CPO council must be formed to guide the entire operation.

Organizing and guiding representative groups in previously unorganized parts of the CPO area will be an important and time-consuming part of this CPO model. This phase of the operation often takes a considerable amount of staff time, energy, and organizational expertise. Home health aides may be able to handle the job, although they may want to get help from professional community organization workers recruited from city or county social workers, from United Way agencies, from Community Resource Development personnel of the county Cooperative Extension Services, or from among health educators.

The main advantages of this structure are that it is easy to understand and that it can reach down into individual homes and families to have a personal impact on the behavior of the people involved in it.

(3) Special Interest Structures:

This model combines the advantages of the preceding two by forming special interest groups made up of representatives from different areas of the community. It especially lends itself to working with a population-at-risk when its members are scattered in a number of large neighborhoods.

This type of CPO structure has a central CPO council which guides any number of special interest groups made up of concerned representatives from the geographic areas in the community which have populations-at-risk. The special interest groups are those existing or formed to deal with prevention planning and programs related to the natural environment pollution, occupational injury and disease, residential safety and sanitation, immunization, nutrition, dental disease, exercise and recreation, and self-imposed risks.

As members of these groups become more informed and interested in their special fields, they also become more influential. In fact, this model increases the clout which consumers and interested citizens can have as they become informed, try to influence public policy, and work with community health and safety programs.

Efforts will have to be made to organize people within each geographic area who are interested in a special subject area. However, this can usually be handled by staff members or consultants from different sections of a public health agency and should not require additional professional help.

(4) Temporary Planning Structures:

These constitute a quick approach to setting priorities for programs and delivery arrangements. They should be used only as a last resort when continuous participation is impossible because decisions must be reached quickly to comply with a deadline or when decisionmakers actually want and need off-the-top-of-the-head reactions from consumers and agency personnel who have not had a chance to become informed or discuss their views.

From 20 to 100 consumers and agency personnel are first brought together in meetings designed to produce a set of priorities. The nominal group process is employed at these initial meetings to establish a consensus openly and without outside interference.

Participants in this process, which usually takes 3 hours, begin by listening to a brief (usually about 15 minutes) presentation by the consultants explaining the procedure. Then they sit in silence for about 30 minutes and write on blank cards what they think are the five most important health needs and the five most important service delivery problems. Silence maximizes individual participation by keeping people from influencing each other in a discussion. At the same time, the presence of a group, even though it is silent, helps each person to concentrate on the task.

During the next 30 minutes, all the items listed on the cards are transferred to wall sheets so that the whole group can see them and discuss them. After about an hour's discussion, a vote is taken on the priority ranking of the items listed. The results of the vote are discussed briefly, and the meeting adjourns.

In this way, citizens and agency personnel form a fleeting but efficient partnership by sharing their perspectives and their interpretations, pooling them, and voting on priorities. These are subsequently brought to decisionmakers by agency staff members who write them up as program proposals. When that is done, the citizen and staff groups are reconvened once more to voice their final reactions to the proposals and to make revisions where necessary.

This approach relies heavily on the initiative and guidance of agency officials, and consultants are likely to be needed to carry it off well. On the other hand, the organizers of this structure will not have to worry about maintaining participation, since participants attend only two meetings.

Needless to say, participants cannot be expected to gain much new information, formulate new ideas, or change their behavior as a result of this experience. Nor is it a useful tool for working with members of minority groups who are far removed from the mainstream of the community. However, it may be an essential tool when time is short and decisions are needed based on information which people already have.

Leadership

At the beginning of the CPO process, while groups and alliances are being formed, people tend to choose an assertive person as their leader. They do this either informally by simply allowing a person to take the lead or by selecting a temporary chairperson.

In any case, the person chosen may or may not be the facilitator--the person responsible for trying to get the CPO organized. But the leader at this stage usually has a great deal of influence on the group's members because they tend to feel uncertain about their roles.

For this reason, leaders during this organizational phase should realize that their position is a temporary one. After a certain amount of groundwork has been done and the group feels some sense of direction, other leaders will emerge and compete for influence. They will offer alternative plans of action, while group members will struggle to decide which of these is most appropriate and which person should take the lead.

When a new leader is chosen, the group tends to become decentralized. No longer is the leader the focus of all attention. Instead, leaders and followers begin to communicate with each other, while ideas and influence flow in several directions at once.

But while the first leader is still in charge of the group, he or she should try to convince its members to concentrate on procedural decisions, rather than on major decisions about program or other long-range plans. It should be pointed out that lasting decisions about the future should be left to a more stable stage of CPO development when the group has attained the perspective and maturity to make such decisions.

STAGE TWO: GETTING ORGANIZED

The preliminary efforts described in the previous chapter have taken us as far as a steering committee. This committee is advised of its temporary status so that its members will understand their role: to work themselves out of a job. If this is not clearly understood, the CPO may never get beyond the steering committee stage because members of the committee may refuse to participate in any efforts to expand and diffuse their power.

In any case, after 3 or 4 months of preliminary planning, it is now time for the staff to move the CPO out into the neighborhoods. It is time to begin to get representation from whatever interest groups or geographical sections of the community are involved in moving toward the CPO's objectives. This expansion process can proceed in stages as time and personnel become available. It might take place in only one sample neighborhood so that organizers can gain confidence and experience. Whatever the approach, the direction of movement is now out from the center.

The job of these neighborhood citizen groups is to establish their own priorities for community action and to recommend the style of action which would be most suitable to them. After the CPO Council is formed, they can then send their representative to report that, for example, "Garbage pick-up is an issue in our neighborhood," or "We've got a problem with packs of wild dogs," or "Our teenagers need health education."

Helping Citizen Groups Organize

Facilitators and the organizers who work with them as staff members usually go out into the community to get meetings started. They help community leaders and other citizens learn about health issues and to understand the organization process better. Learning by doing is, of course, the best and least embarrassing way for adults to learn about both.

Facilitators should take a back seat in this learning process, guiding the citizens' development with a light, encouraging hand. They should be careful not to exert undue influence on opinions, not to take the ball away from the participants, and not to turn off or embarrass participants in any way.

One way in which facilitators can be particularly helpful is to recognize and encourage potential leaders in the community--people who are natural leaders even though they may not have training or experience and may not be involved in any community work. Potential leaders are people who have more energy than they need for their daily routines and who care more about other people than the average person. They visit the sick or help out people in need. They often stop to chat with others because they seem to know almost everyone. Facilitators have to find ways of making others aware of this potential and of making the potential leaders want to step forward and take charge. Since the subtleties of personality interplay are so important, especially in the initial stages of a group's organization, it is often useful to keep a healthy balance between work and play, and discussion and social activities. Of

course, the urgency of a problem is what brings citizens together in the first place. But this does not mean that they could not find more in common if they had a chance to chat informally over a cup of coffee or a picnic lunch.

Once human chemistry begins to work between people through social activities, their capacity for joint effort is usually strengthened. On the other hand, if the group does not have a good reason for working together at the start, or if it has not had the help it needs to get organized, no amount of cookies, potluck suppers, or other celebrations will make up for those basic deficiencies.

Organizing Disadvantaged Citizens

One of the most important jobs organizers have is to convince those who are outside the mainstream of society that it is desirable and worthwhile to organize for community action. Only after this is done can these citizens begin to organize, again with the help and encouragement of facilitators. Very often the people who are members of minority groups by virtue of their skin color, nationality, language, culture, or income are also members of high-risk populations when it comes to illness or injuries. Very often these same people are also separated from the mainstream of society by geographical, language, or cultural barriers.

Whatever the barriers might be, these same high-risk groups are also often the hardest to reach and certainly the hardest to organize. Many so-called citizen participation projects have floundered because it was so difficult to attract these people and to get or hold their interest. The disadvantaged person is often suspicious of a public agency's motives, inexperienced in the democratic process, and unschooled in public health matters. Furthermore, people on the cultural sidelines are not used to speaking up, making suggestions, or—least of all—arguing with people in positions of authority.

Disadvantaged people tend to feel awkward with people unlike themselves, particularly those who seem to be either richer or smarter than they are. They are hesitant to step outside their own home ground, both literally and figuratively. Quite often they also have an attitude of resignation about whatever life has to offer. When confronted with a problem, their reaction is more likely to be, "That's life," instead of, "We'd better get busy and do something about this."

People outside the mainstream of society will, of course, feel most comfortable (and least threatened) by a facilitator who is a member of their own subculture. It is therefore worth the time and trouble to find someone or train someone from the subculture to do the job of facilitator.

If this is not possible and an outsider has to help the group, that outsider will have to do his or her utmost to be well understood. Naturally, this will require an openness, empathy, and sensitivity which permit the facilitator to learn quickly to understand the people in the group, to see things from their vantage point, and to talk their language. (Sometimes the facilitator may literally have to learn to talk another language.)

It is important, too, to find out leadership preferences of an ethnic or cultural subgroup. Do they like strong, authoritative leadership? Do they have special regard for doctors and other health professionals? For older people? For men?

Once a facilitator has started working with a group, it is usually a good idea to get some visible change made as soon as possible to reinforce the citizens' faith both in him or her and in the CPO process. They will probably be considerably impressed if facilitators can demonstrate that they have the support of people whom the citizens respect: politicians, professionals, elected officials, teachers, or whoever it may be.

One obvious way to demonstrate this is to invite one of these persons to a meeting to express interest in what the citizens are doing and offer encouragement. Another way is to ask the appropriate person to come to the community to inaugurate a change: to cut the ribbon on a new birth control information center, to place the first call on a new telephone information service, or to hand over a check for a new rate control program.

One of the pitfalls of becoming a friendly, helpful, accepted facilitator is that participants may one day ask him or her to serve as their advocate for a local or personal cause. For this reason, it is a good idea to clarify the facilitator's role right at the beginning and to remind participants occasionally that the facilitator is an advocate for participation and nothing else. Citizens can and should speak for themselves. In fact, that is what a CPO is all about.

Urge them to look again for undiscovered leaders in their own midst who can be excellent spokespersons for the group. Or explain that training programs can be made available to some or all of the participants to help them become more effective advocates for their own causes. This is true, too, of becoming a spokesperson for a citizen group when it has differences with another citizen group. There again, each group should speak for itself and not expect the facilitator to be a mediator between the two parties.

You might also remind participants of what facilitators can and should do. First of all, they should help set the rules of discussion and negotiation and then help enforce those rules so that everyone's voice will be heard and everyone has an opportunity to influence the group. In general, facilitators should help formulate and back up organizational rules which guarantee the dignity and value of each participant and of what that participant has to say.

Obviously, the change from suspicious, alienated individuals to trusting, participating group members will not come about overnight. Facilitators should remind themselves and each other that it takes patience and time to make this happen. To establish trust, interest, loyalty, and enthusiasm in a new group which never existed before is not a job for the fainthearted or impatient. But until all the high-risk, highly alienated segments of the community are well organized, the CPO cannot proceed.

The CPO council, for example, should not be formed until a sizeable number of segments of the community are organized and until most groups know who their leaders are and what their priorities should be. Since the CPO council has to weigh the priorities which are voiced by the participating community groups, the council cannot go to work until most groups have made those decisions. Besides, disadvantaged neighborhoods which are relatively unorganized will feel even more at a disadvantage if the CPO council has already been in business for some time when they join. They will feel left out and rightfully so.

In many cases, all groups in the community will be organized by the end of the first year's efforts. That means they will have spent 6 to 8 months getting together and getting started. But there will always be exceptions. Sometimes people in a neighborhood who have made no move to get organized may begin to get together when they see everyone else has already done so and they are the only ones not participating. Having once made that decision, even if it took months to make, they may then get organized in a relatively short time.

Maintaining Participation

Perhaps the most vexing problem for the facilitator of a CPO (or any program which requires citizen participation) is the business of getting and maintaining participation from those whose participation is most needed: the high-risk, disadvantaged members of the community.

Whether they are disadvantaged by virtue of low income, insufficient education, or cultural isolation from the mainstream of society, most disadvantaged people are afraid or suspicious of efforts to help them. They are doubly afraid and suspicious of efforts aimed at putting them in a decisionmaking capacity. They frankly do not believe that they can or will have a voice in their own destiny. That being the case, they assume they are being used, patronized, or that someone is taking advantage of them in one way or another.

This being the case, the first and biggest hurdle facilitators have to surmount is to convince these citizens that they indeed have influence in promoting health and preventing illness and injuries. Not only will they have influence, they will be partners with the agency in the community health enterprise.

It is important to explain that this does not mean that each one of their suggestions will be acted upon or that all their ideas will be implemented. Facilitators should make it clear that this is not true of agency plans either. What it does mean is that each area unit or special interest group will be heard, their suggestions considered, and that every effort will be made to respond to their top priorities.

For their part, citizens must give agencies the same consideration. They must listen to the agencies' points of view, learn what their limitations are, and do what they can to help agencies satisfy the needs of all citizens.

Again, the challenge will be to repeat this message often enough and in different enough ways so that citizens actually believe what they hear. Facilitators should keep in mind, though, that most of us believe what we see more quickly than what we hear. This being so, disadvantaged groups should be given the chance to experience successes or to see the success of others as soon as possible.

Conversely, they should be protected at all costs from disappointment or disillusionment at the beginning. It will take very little failure or disappointment to convince people who are already low on confidence that their efforts are useless and that they do not have any say in the community after all.

Techniques for Working with Citizens

You may be thinking that some of these tasks are easier said than done. But there are techniques that have worked successfully and may inspire you to think of others. For example, remember that agency personnel have an 8-hour working day to get things done. Citizen participants, on the other hand, do their work at the end of an 8-hour working day. This means they should not be expected to attend meetings during the day; they should not have to meet at all unless a meeting is well prepared and absolutely essential.

In addition, keep in mind that a citizen volunteer group cannot work as quickly as an experienced, paid, well-organized staff working all day long. Any timetable that is set up should take into consideration the fact that community groups are not experienced, not as well organized (even at their best) as a paid staff, and do not have the time or energy of a full-time worker. This realization will eliminate the frustration and disappointment which result from unrealistic time schedules and deadlines.

When a meeting is planned, it will be better attended if clear, attractive announcements of the meeting are featured in newspapers or announced on the radio. The meeting can also be announced in a supportive way by respected people, such as the minister of a local church, the director of a recreation center, the principal of a school, or the president of a popular local club.

The announcements should make it clear to participants that the meeting is necessary and worth their time. It should also explain what will be discussed and what is expected to happen as a result of the meeting. Above all, the announcements of the meeting and its agenda should answer these questions: What is in it for me or my neighborhood? What will this meeting do to improve my life or my neighborhood?

Answers to these questions might include mention of some tangible benefits which participants can derive from the meeting and subsequent meetings of the CPO. Explain how their participation could lead to fewer accidents, fewer preventable illnesses (and more are preventable than they might think), fewer

sick days away from work and school, better pay and better grades, lower medical and dental costs, and more and better health services for their neighborhood. It is best to mention specific needs and services.

Less tangible benefits might include the social benefits of meeting new people, making new friends, having a stronger feeling of belonging to the community, and having more community spirit. Being a participant or a leader in a community organization gives people an outlet for talents they might not be able to use on their job or at home. It gives them the satisfaction of changing something in their world instead of living with complaints.

You can heighten participants' feelings of status by asking some of the doubters to poll the opinions of their friends and neighbors on needs or deficiencies. If the need for this information is well publicized in advance, those who are collecting it will feel even more prestigious. Besides, the exposure to other people's opinions will help make them more knowledgeble and more interested--in short, more willing to work toward remedying whatever situation they explored.

Of course, when people are elected or appointed to office, they are rewarded by the confidence of their peers. This feeling can be strengthened by giving certificates or some other tangible token of recognition to those who lead or work for their group in any capacity. Awards can also be given to followers for good attendance at meetings or simply for participation.

If certificates are used, they should be signed by a person who is prestigious in the eyes of the people who receive the awards. Photographs of leaders and participants in the newspaper are also ways of acknowledging efforts, as are feature stories about groups or individuals. These stories and pictures are usually easy to arrange, but they should be placed in the newspaper which the participants read and respect (this may or may not be the major daily).

Other ways of bestowing honors on the participants will probably come to light if facilitators take the trouble to find out how people are rewarded in the particular group they are working with. Each culture has its own way of honoring its outstanding members.

Organizing the Interagency Council

In most communities, the organization of residents in neighborhood associations, if needed and if none exist, will have to come first simply because citizen groups take more time to organize. But as soon as possible an intergency council will have to be formed in order to get the cooperation of existing organizations in the CPO council and the CPO as a whole.

Some communities may already have an interagency council for health matters. Others may have one that is associated with United Way, a Chamber of Commerce, citizens' forum, or local and regional planning. But even where there is no interagency organization, it should be less difficult to form a council

because, unlike neighborhoods, the agencies themselves are already organized. This task is easier if there exists a community service directory listing all such organizations that should be represented.

In most cases, facilitators will simply need to ask the director of each agency to be the representative for that agency on the interagency council, or to assign another top-level person (preferably the deputy director) to that job. The representative speaks for the agency--makes suggestions or expresses reservations--whenever priorities are being considered or plans for action made.

Sometimes agencies in a community suspect the agency that initiated the idea of a council is trying to take over the leadership of it or play the dominant role. For this reason, a very neutral style of organization is needed. When the idea of forming an interagency council is proposed, it should be clear that each agency can expect to achieve its own purposes through such a council as well as the objectives of the CPO.

Organizing the CPO Council

Around the end of the first year, many communities will be ready to form a CPO council. The council usually consists of representatives of citizen groups and agencies. Because citizens are often less knowledgeable and experienced about asserting themselves, most CPO councils have to have more citizen members than agency members in order to establish a power equilibrium.

The job of the CPO council is to discuss and consider the priorities that have come out of the health, social, fraternal, and civic agencies as well as those that have come up from neighborhood groups. It then can form a well-ordered set of priorities for the CPO as a whole. For this reason, a CPO council cannot be formed until most of the neighborhoods--including those whose residents have lower educational levels, those with ethnic minorities, and those with residents speaking different languages --are organized and have had time to select their leaders and come to grips with their own priorities. Until that time, there is really nothing for a central CPO council to do.

The priorities which the CPO council espouses are translated into action, either by the self-help effort of the area residents or persons at-risk or by the public or the private health agencies (and cooperating environmental, housing, and recreation agencies) who then deliver the services where and when they are needed. Through the mechanism of the council, suggestions continue to flow in from neighborhoods and member organizations about the best ways of delivering those services and about the impact which the services have on the people in the community. At the same time, the agencies continue to feed into the CPO council information about problems they are facing, so that citizens can help them surmount these problems.

STAGE THREE: DELIVERING SERVICES

As soon as the CPO is organized, from neighborhood subgroup to central CPO council, it can start planning programs for the prevention of disease and injury and supplementing the work of agencies in delivering services.

At this point, all levels of the CPO should be discussing:

(1) Their objectives in order of priority; and

(2) Ways and means of reaching their objectives. If necessary, citizen groups may want to conduct surveys or get information from agencies to help them decide what their most pressing needs are. Once decisions have been reached, citizen groups can consider various avenues of action.

Role of Citizen Groups

For example, if a citizen group's number one priority is rat control, citizens in a community may want to bring the pressure of public opinion to bear on businesses, such as restaurants and grocery stores, which are not disposing of their garbage properly.

Secondly, they may want to inaugurate self-help activities, such as organizing local teenagers to clean up empty lots, back alleys, or other areas where a great deal of litter has accumulated.

Thirdly, they may want to volunteer time to work as health education aides who could help individuals and businesses learn more about rodent control measures. Finally, they could work with city departments to get more frequent garbage pickup or to supply rat poison.
Meanwhile, news of all these activities should be getting back to all the citizens in the neighborhood so they will know how they can help make these strategies work toward the common goal: eradicating rats in the neighborhood. When the objective has been achieved, everyone should know about the success of the program so that there will be renewed interest and enthusiasm for continuing work on other projects. Leaders in the community group should think through and evaluate the completed project so they can gain confidence and satisfaction from what was done well and learn from the mistakes that were made.

In the case of a rat control program or any program designed to change the behavior of citizens, it is a difficult task for agency personnel to tell people that they must start keeping their homes and yards clean. The expressed and implied criticism citizens hear is that their way of life is unhealthy or that they do not work hard enough or well enough in their own homes.

On the other hand, their neighbors may be able to get the message across better than an outsider from a health agency. Neighbors are less likely to be resented or tuned out if they can show how, for example, they handled

trash disposal in their own homes by following certain rules of good housekeeping. The citizens on the receiving end of such a message will have respect for the person who is passing along this information and will have the feeling that they are trying to be helpful rather than critical.

Role of Agencies

Community health aides or a paid person with an equivalent job from the neighborhood can also provide information and suggestions, all of which can be blended with help from health agencies and other government services and with reinforcement by community leaders, handouts, and information in the media.

Services can be designed to rotate from one neighborhood to another. An intensive effort in one neighborhood can get a project started and well enough along the way so that neighborhood people can keep it going by themselves. Agency personnel or CPO staff members can then move on to the next neighborhood for an intensive effort there.

Meanwhile, citizens should be letting agencies know what is and is not working on their behalf. Is the rat poison being placed where children can find it? Are clinic hours set for a time when working mothers cannot get there? Is the person working with teenagers in the family planning center too formal and authoritarian to do a good job? If so, citizens can register their complaints as well as their suggestions for making service delivery more effective and efficient through the mechanism of the CPO.